INTRODUCTION - VEGETATIVE STATES

There are three cases that have played a major role in shaping how medicine addresses persons in a vegetative state. In previous modules, we have looked at the case of Karen Ann Quinlin and the case of Nancy Cruzan. In this module, we will address issues concerning the ethical treatment options for persons in a vegetative state by examining the case of Terri Schiavo.

Terri Schiavo wanted to lose weight. Her diet consisted of replacing meals with 10-15 glasses of Iced-tea each day. This led to an electrolyte imbalance and Terri went into cardiac arrest. When her husband found her, she had stopped breathing and there was no pulse. Even though the paramedics were able to revive her, Terri never regained consciousness. At the age of 27 she had entered a vegetative state.

At first the doctors tried a variety of therapies hoping that Terri would regain consciousness. After several years without results it was deemed that her vegetative state was permanent. In 1998, eight years after her heart attack, her husband Michael petitioned the Circuit Court to have her feeding tube removed. Terri did not have an advance directive but her husband Michael testified that she had often indicated that she would not want to be kept alive with little or no hope of recovery.

The Court supported the Michael’s petition but Terri’s parents objected and received a judgement from a local court to maintain assisted nutrition. Their primary argument was that Terri was a devout Catholic and would not have wanted to participate in what they believed was a passive form of euthanasia.

Terri’s husband Michael and her parents battled through the courts for the next seven years. While the federal courts consistently supported Michael’s desire to withdraw nutrition and hydration, other civic entities including the Florida legislature, the Florida Governor, The United States Congress and the President at the time, all tried to find a way to deny the withdrawal of Terri’s feeding tube. When the Supreme Court refused to hear the case. Nutrition was withdrawn on March 18, 2005 and on March 31, at the age of 41, Terri Schiavo died.

VEGETATIVE STATES

A vegetative state is a condition where the person is in a coma and may appear awake. A person in a vegetative state may open his or her eyes and demonstrate the presence of a sleep cycle though typically a person in a vegetative state does not respond to sound, hunger or pain. Persons in a vegetative state do not demonstrate purposeful actions, show awareness or understanding and are unable to interact meaningfully with others.

A persistent vegetative state (PVS) is a vegetative state that has lasted for a month. The PVS is considered permanent when all reasonable treatments have been tried and the chance of consciousness is highly unlikely. The rare patients who do recover consciousness after a year in a PVS experience significant disability.
SLIDE 3 TREATMENT OPTIONS FOR PATIENTS

Treatment for those in a persistent vegetative state tends to be very ordinary, the minimal care that any sick person would receive. In most cases, those in a PVS find swallowing food and water difficult, if not impossible, therefore they receive nutrition and hydration through tube feedings. Basic hygiene practices such as bathing are followed along with necessary cleaning and disposal of waste.

Patients need to be routinely moved to avoid bed sores and to prevent blood clots. Patients can be susceptible to infections and may receive antibiotics or even prophylactic treatment such as flu shots. Extraordinary care is optional and depends on the wishes of the patient or on the direction of the surrogate.

SLIDE 4 WITHDRAWING OR WITHHOLDING OF LIFE SUSTAINING TREATMENT

The U.S. Constitution grants patients the right to refuse all medical treatment. This right is valid for all people, even those who lack the capacity to make decisions. Therefore, when making a decision to withhold or withdraw treatment for a person in a persistent vegetative state, the first consideration is the patient’s wishes.

Since in this case, the patient has neither capacity nor the ability to communicate directly autonomy is then exercised through an advance directive. If no advance directive exists, autonomy can be exercised through the testimony of others who have discussed the matter with the patient.

When there is no indirect evidence of the patient’s wishes autonomy is exercised through substituted judgement. Here an attempt is made to determine the patient’s wishes through personal knowledge of the patient’s values, fears, preferences and behavior patterns.

SLIDE 5 SURROGATES (PROXIES)

Surrogates speak for patients who cannot speak for themselves. Even when the will of a patient in a vegetative cannot be known either directly or by substituted judgement, a surrogate speaks for that patient. In this situation, the primary role of the surrogate is to preserve the patient’s autonomy by making the decisions that are in line with those that most people in a similar situation would make.

SLIDE 6 DUTIES OF THE SURROGATE

The duties of surrogates are first to protect the patient’s autonomy by making decisions based on the patient’s stated desires or inferred wishes. When it is not possible to consider the stated desires or inferred wishes of the patient, the surrogates makes decision based on the patient’s best interest.

Best interest is determined primarily by looking at the benefits and the burdens that a treatment decision imposes on a patient. These benefits and burdens are determined by applying the principles of beneficence and non-maleficence. First the principle of non-maleficence is applied. What burdens will a treatment impose on the patient? Will it cause distress? Does it have the potential to make conditions worse?

Next the question of benefits arises. Treatments that improve the patient’s life without imposing burdens are acceptable. For instance, a flu shot imposes little if any pain for the patient but could prevent respiratory distress. Imposing burdens on a PVS patient without corresponding benefits is unethical.
In addition to looking at specific treatments that may impose benefits and burdens to the patient, surrogates can also consider quality of life. In the case of a patient, with PVS, quality of life only refers to the condition of a living patient before treatment compared to that same patient after treatment. Quality of life cannot be considered as criteria for determining that the life of the person in a persistent vegetative state has no value and therefore is no longer worth living. That being said, because the right of the patient to refuse treatment remains even in a PVS, the surrogate can, exercise that patient’s right to refuse or withdraw treatment when there is clear and convincing evidence that the patient would make the choice to end treatment.

SLIDE 7 EUTHANASIA and PHYSICIAN ASSISTED DYING

There are some individuals with a terminal diagnosis and whose life is moving toward its end who find that life itself has become such a burden that they have determined that it is no longer worth living. They may be suffering from continued pain; they may fear further deterioration or the indignity of the dying process. Some may believe that their lives have become a burden for their loved ones and desire to lessen the pain of those they care about.

The options are limited. Most find a way to endure the burdens of dying. Others look for relief. They may consider euthanasia, asking someone to help them end their life. Euthanasia, sometimes called mercy killing involves the intentional and direct killing of another person in order to relieve suffering.

SLIDE 8 EUTHANASIA

“Euthanasia, sometimes called “mercy killing,” comes from the Greek word meaning “good death.” The idea is that a pain free death is a good death. Euthanasia describes cases where someone’s death is intentionally and directly brought about through the actions of another person, usually to reduce pain and suffering. Euthanasia can be either voluntary or involuntary. Voluntary euthanasia describes cases where the person with decisional capacity has consciously and intentionally requested death. Involuntary euthanasia refers to acts that intentionally cause the death of people without capacity and without their expressed wishes. Involuntary euthanasia is universally condemned even though it may be done in order to reduce suffering.

SLIDE 9 PHYSICIAN ASSISTED DYING

When these terminally ill people are under the care of a physician, they may seek help in bringing about a swift end to their life. This causes a dilemma. Euthanasia is illegal in the United States even if it is done out of sympathy and with the person’s permission. Furthermore directly acting to end a patient’s life is “fundamentally incompatible with the physician’s role as a healer” (AMA).

Still, some physicians find the suffering that some patients undergo at the end of life to be unnecessary and are willing to aid a patient already in the dying process to bring a quick end to an inevitable outcome. This is called physician assisted dying or physician assisted suicide. The reasoning is
that while the direct killing of a patient is unethical, indirectly providing the means of helping a patient commit suicide is acceptable.

For example, if a patient with a terminal condition requests aid in dying, the physician can indirectly provide the requested aid by giving a patient a prescription for a lethal dose of a medicine, allowing the patient to exercise autonomy and choose the time, place and means of their own end.

While euthanasia is illegal in the United States, physician assisted dying is currently legal in six states, Oregon, Washington, California, Colorado, Montana and Vermont. Physician assisted dying or physician aid-in-dying involves a physician providing a patient with the means to take his or her life. Typical requirements are that the patient has a terminal diagnosis with less than six months to live and that the patient has decisional capacity.

SLIDE 10 ANALYSIS OF PHYSICIAN ASSISTED DYING

Arguments for physician assisted dying are usually drawn from the principles of autonomy and beneficence. First it is generally recognized that individuals with the capacity to make decisions possess the right to make choose or reject medical treatments even when those treatments would sustain their lives. A person with capacity who is not actively dying even has the right to refuse nutrition and hydration. Why then shouldn’t an autonomous person at the end of life decided to bring about their inevitable end quickly and painlessly under the supervision of their doctor?

The principle of beneficence states that it is good to act in ways that reduce the suffering of others. Physicians, by nature of their profession have the best tools for reducing suffering for patients at the end of life. Some argue that in addition to the pain that can accompany dying there is a loss of dignity. Patients at the end of life can lose control of their abilities and their bodily functions. Adults may become infantilized. Some argue that it would be better to avoid the “indignity of dying” by taking one’s own life with the assistance of a doctor.

Arguments against physician assisted dying are primarily natural law arguments. Natural law arguments are based on an understanding of human nature. Humans have a natural drive to protect and extend their own lives and to preserve the lives of others. Survival is a natural human good. Intentionally acting to end one’s own life, regardless of its condition, goes against human nature.

Furthermore humans by nature regard killing as something to be avoided whenever possible. In this sense the needless killing of another human is unnatural. There are many other ways in which suffering can be avoided without killing. For example, with palliative sedation a patient can minimize suffering. This makes the acts of killing, either directly or indirectly, unnecessary and against human nature.

Finally, the AMA argues that directly assisting a patient to die is “fundamentally incompatible with the role of a physician as healer.” Since the intention and possible the means are the same, it is not clear why indirectly assisting a patient to die is different from direct assistance. Physician assisted dying may not differ substantially from voluntary euthanasia.